

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10095

CERTIFICATE OF DEATH

10095

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb Adult life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 200 Myrtle Street		d. STREET ADDRESS 200 Myrtle Street	
3. NAME OF DECEASED (Type or print) T. Clyde Covington		First T.	Middle Clyde
4. DATE OF DEATH July 1, 1967	Month July	Day 1	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH Dec. 21, 1892
8. AGE (In years lost birthday) 74 yrs.	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (County & State, or foreign country) Camden, N. Jersey	
13. FATHER'S NAME Thomas Covington		14. MOTHER'S MAIDEN NAME Margaret Elizabeth Selby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-03-0801	17. INFORMANT Mrs. Beatrice Covington, Same as 2. abcd	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malabsorption Syndrome INTERVAL BETWEEN ONSET AND DEATH 1 year DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Mental Depression DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 1967, to July 1 , 1967, that (I) (we) last saw the deceased alive on July 1 , 1967, and that death occurred at 9 A.M. from causes and on the date stated above.			
22a. SIGNATURE Sarah M. Peyton		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED July 5, 1967
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D.		22d. ADDRESS 33 W. Main St., Crisfield, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 4, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery
23d. LOCATION (City or Town) Crisfield, Md.		(County) (State)	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE JUL 6 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10094

CERTIFICATE OF DEATH

10096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover	d. STREET ADDRESS RT # 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Dennis	4. DATE OF DEATH Month July Day 25 Year 1967
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Mar. 25, 1888
9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (County & State, or foreign country) Hanover Md	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Dennis	14. MOTHER'S MAIDEN NAME Hester Whittington	Address Pauline Dennis Marion Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Pauline Dennis Marion Md.	18. INTERVAL BETWEEN ONSET AND DEATH 36 hrs
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO stating the underlying cause (c) DUE TO Central Venous Accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/26 , 1966, to 7/25 , 1967, that (I) (we) last saw the deceased alive on July 25, 1967 and that death occurred at 8:15 M, from causes and on the date stated above.			
22a. SIGNATURE A. N. Barr		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7/28/67
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		22d. ADDRESS Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Marumsco	23d. LOCATION (City or Town) (County) (State) Marion Md.
24. FUNERAL DIRECTOR Hathaway E. Ward Crisfield Md	ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 4 1967	25b. REGISTRAR'S SIGNATURE Charles J. Rogers

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FOR STATE
HEALTH-DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH												10097	
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crisfield, Maryland				d. STREET ADDRESS Main St., Ext.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First HOWARD	Middle GLENWOOD	Last EVANS	4. DATE OF DEATH July 29 1967		Month July	Day 29	Year 1967				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1947		9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 19	IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY College			11. BIRTHPLACE (State or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME R. Preston Evans				14. MOTHER'S MAIDEN NAME Carolyn Howard									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address R. Preston Evans, same as 2. abcd above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head Injury													
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Automobile Accident													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Rt. # 413								INTERVAL BETWEEN ONSET AND DEATH Instant	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 3:20 AM 7/29/67				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) R.F.D. Crisfield, Maryland		(County) Somerset		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Everett Sutter</i>													
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
Address (Street, city, town, or county) Somerset													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d. LOCATION (City, town or county) Crisfield, Md.							
24. FUNERAL DIRECTOR Bradshaw & Sons		ADDRESS Crisfield, Md.		25a. REC'D BY REGISTRAR AUG 4 1967		25b. REGISTRAR'S SIGNATURE <i>James J. Sutter</i>							
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE
HEALTH DEPT

10096

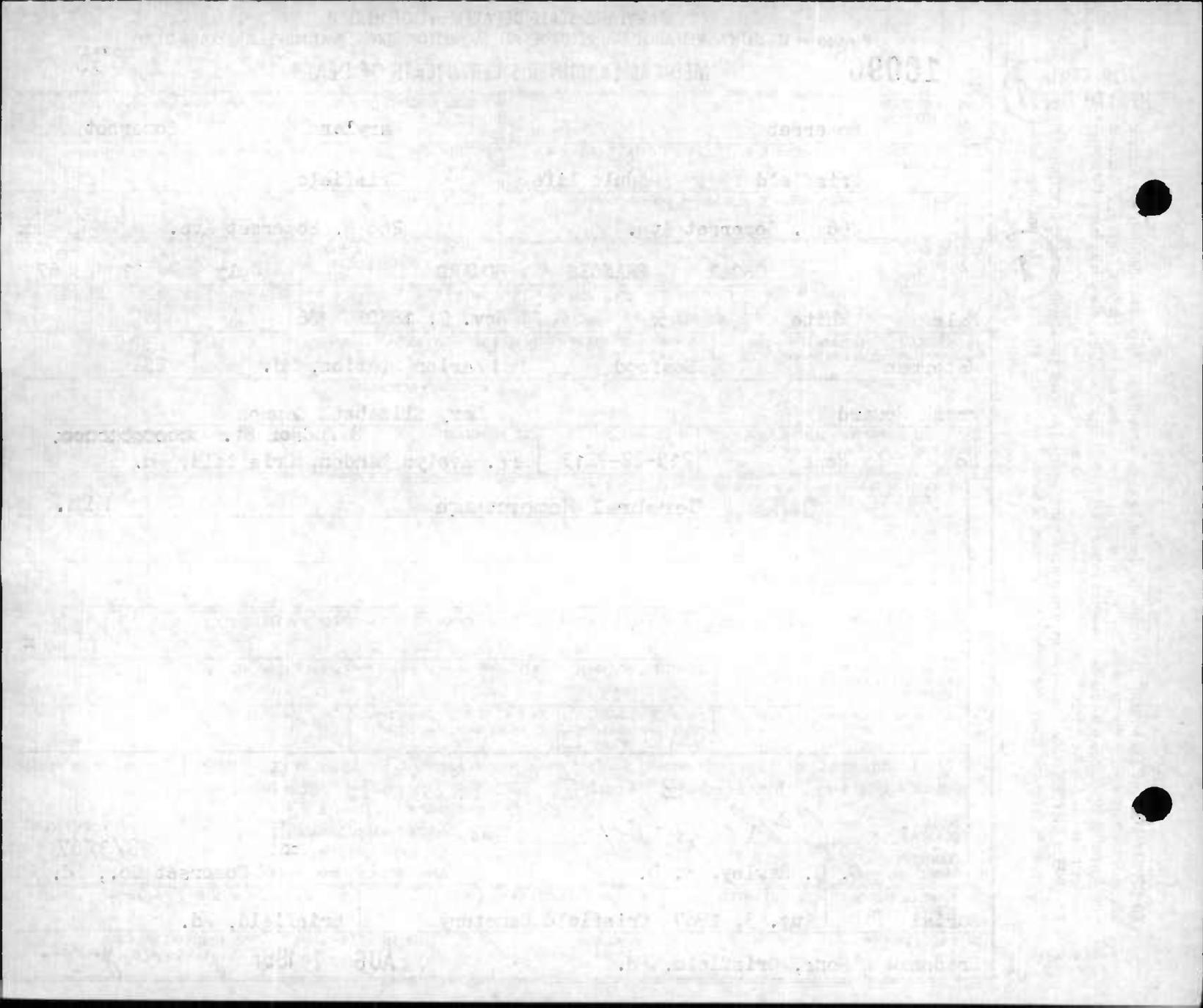
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10098

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1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		b. COUNTY Somerset				
c. LENGTH OF STAY IN lb Adult life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 266 N. Somerset Ave.		d. STREET ADDRESS 266 N. Somerset Ave.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) OSCAR FRANCIS HOWARD		4. DATE OF DEATH July 31 1967	Month Doy Year			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 7, 1880			
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		IDb. KIND OF BUSINESS OR INDUSTRY Seafood	9. AGE (In years lost birthday) 86 yrs.			
11. BIRTHPLACE (State or foreign country) Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Frank Howard		14. MOTHER'S MAIDEN NAME Mary Elizabeth Cannon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-9213				
17. INFORMANT Mrs. Evelyn Landon, Crisfield, Md.		8 Hudson St. Address 200-2000				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause } lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Min.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>C. G. Rawley.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) C. G. Rawley, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 3, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery	23d. LOCATION (City or Town) (County) (State) Crisfield, Md.		
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 7 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												10099	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Somerset				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland				b. COUNTY Somerset					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Md				c. LENGTH OF STAY IN 1b Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Oscar B James				First	Middle	Last	4. DATE OF DEATH 7-17-67	Month	Day	Year			
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1890	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				11b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Woodland P James				14. MOTHER'S MAIDEN NAME Julia C Logan				Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 214-01-7942				17. INFORMANT Elsie Tilghman (Princess Anne, Md.)					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Myocardial infarction												INTERVAL BETWEEN ONSET AND DEATH seconds	
H201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b)	Coronary arteriosclerosis				years				
				DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Juett Sutter</i>												22. DATE SIGNED 7-19-67	
EXAMINER'S NAME (Type) Everett Sutter MD				Address (Street, city, town, or county) Somerset									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7-22-67				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS John Wesley				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR William H James III, Princess Anne, Md.				25a. REC'D BY REGISTRAR JUL 26 1967				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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М. А. Бондарь

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Санкт-П. Красн.

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Новод. П. А.

Санкт-П. Красн.

(М. А. Бондарь) маниф. санит. СПб-10-100

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* М. А. Бондарь

Люб. Матвеев

С-П-У-Г

Фот. У. С. Ю.

* М. А. Бондарь, Т.И. Бондарь

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10098

CERTIFICATE OF DEATH

10100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb years 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Virgil	Middle H.	Last Maddox
4. DATE OF DEATH Month July Day 22 Year 1967	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Month Dec Day 16 Year 1903	9. AGE (In years last birthday) 63 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (County & State, or foreign country) Marion, Md.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Benjamin Maddox	14. MOTHER'S MAIDEN NAME Mary Emily Howard	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None
16. SOCIAL SECURITY NO. 218-01-2850	17. INFORMANT Mrs. Jeanette Maddox, Same as 2. abcd above	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO stating the underlying cause (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/20 , 1967, to 7/22 , 1967, that (I) (we) last saw the deceased alive on 7/22/67 19____, and that death occurred at 7:20A from causes and on the date stated above.			
22a. SIGNATURE <i>S. M. Peyton</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) S. M. Peyton, M.D.	22d. ADDRESS Crisfield, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 25, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery	23d. LOCATION (City or Town) (County) (State) Crisfield, Md.
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.	ADDRESS	25a. REC'D BY REGISTRAR JUL 28 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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1 **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

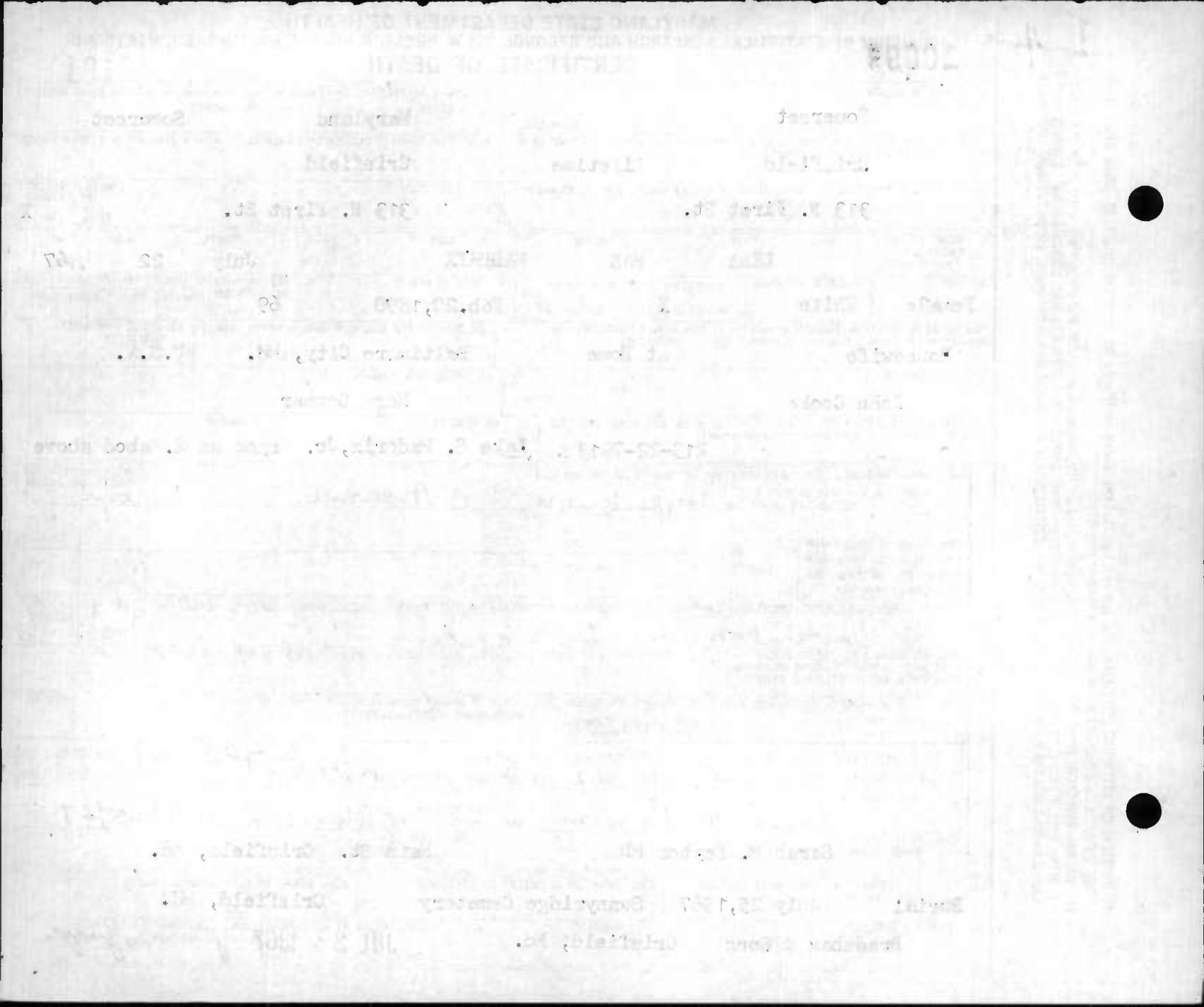
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

10101

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 313 N. First St.		d. STREET ADDRESS 313 N. First St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LENA	Middle MAE	Last MADDRIX
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Cooke	14. MOTHER'S MAIDEN NAME Nora Conner	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 213-22-7913		17. INFIRMARY Lake S. Maddrix, Jr.	Address same as 2. abed above
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Hypertensive C. V. Disease DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastrectomy for Gastric Ulcer -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) from July 22, 1967, to July 22, 1967, that (I) (we) last saw the deceased alive on July 22, 1967, and that death occurred at Crisfield, Md., from the causes and on the date stated above.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) Main St. Crisfield, Md.
21. I certify that (I) (this hospital) attended the deceased from July 22, 1967 , to July 22, 1967 , that (I) (we) last saw the deceased alive on July 22, 1967 , and that death occurred at Crisfield, Md. , from the causes and on the date stated above.		22b. DATE SIGNED 7/25/67	
22a. SIGNATURE Sarah M. Peyton		22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton MD	ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery
24. FUNERAL DIRECTOR Bradshaw & Sons		ADDRESS Crisfield, Md.	25a. REC'D BY REGISTRAR JUL 28 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
10100				10102											
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield											
c. LENGTH OF STAY IN 1b 16 years															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 111 Second St.				d. STREET ADDRESS 111 Second St.											
3. NAME OF DECEASED (Type or print) CHARLES First DEWEY Middle McMANN Last				4. DATE OF DEATH July 22 1967											
5. SEX Male				6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH Dec. 17, 1902		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian				11b. KIND OF BUSINESS OR INDUSTRY Church		11c. BIRTHPLACE (County & State, or foreign country) Tangier Island, Va.		11d. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John McMann				14. MOTHER'S MAIDEN NAME Virginia Crockett											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Alma McMann, same as 2. abcd above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis DUE TO Conditions, If any, which gave rise to immediate (b) Coronary atherosclerosis DUE TO cause (a), stating the (c) Precious Cardiac Imparation underlying cause last.															
4201 INTERVAL BETWEEN ONSET AND DEATH Immediately 10 yrs. 2 yrs.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crisfield		(County) Md.		(State)			
21. I certify that (I) (this hospital) attended the deceased from July 4, 1967 to July 22, 1967 , that (I) (we) last saw the deceased alive on July 22, 1967 , and that death occurred at 2:30 AM , from the causes and on the date stated above.															
22a. SIGNATURE Sarah M. Peyton				22b. DATE SIGNED JULY 24, 1967											
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, MD				22d. ADDRESS Main St. — Crisfield, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 24, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town or county) Crisfield, Md.				(State)			
24. FUNERAL DIRECTOR Bradshaw & Sons				ADDRESS Crisfield, Md.								25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 2DM 1/65				DATE JUL 28 1967											

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10101

CERTIFICATE OF DEATH

10103

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ewell		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ewell		d. STREET ADDRESS Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DANIEL THEODORE SOMERS		First	Middle	Lost	4. DATE OF DEATH July 18, 1967	Month	Day 18	Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1887	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State, or foreign country) Smith Island, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Daniel S. Somers				14. MOTHER'S MAIDEN NAME Arintha Tyler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-7750		17. INFORMANT Mrs. Ruth Smith, Same as 2. abcd		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure						INTERVAL BETWEEN ONSET AND DEATH			
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO Atypical pneumonia				7 days			
		(c) DUE TO Cardio-vascular-renal disease				10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile cataracts, bilateral						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Not an accident							
20c. TIME OF INJURY Month, Day, Year Hour o.m. None		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) None		20f. CITY OR TOWN (County) (State) Not an accident			
21. I certify that (I) (this hospital) attended the deceased from July 1, 1967 , to 7/18/1967 , that (I) (we) last saw the deceased alive on 7/17/1967 , and that death occurred at 145 M. from causes and on the date stated above.									
22a. SIGNATURE Thomas C. Gentry, M. D.		ATTENDING PHYS. M.D.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/20/67			
22c. PHYSICIAN'S NAME (Type) Thomas C. Gentry, M. D.		22d. ADDRESS Ewell, Smith Island, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 21, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Ewell Cemetery		23d. LOCATION (City or Town) Ewell, Somerset, Md.		(County) (State)	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		ADDRESS		25a. REC'D. BY REGISTRAR JUL 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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unseen

extreme lateral shift

automotive vs. rail system

allowable range to travel at below

• All drivers allowed within 60-62 x

center mark

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80-11-7 January

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GM safety review

443 1981 + 1 JU